Theme 4: Developing FFS Payment and Service Delivery Systems

Summary: All the new prospective payment systems (PPSs), e.g., skilled nursing facilities (SNFs), home health, inpatient rehabilitation, and outpatient and long-term care hospitals, are being evaluated as they proceed through the successive stages of implementation. Refinement efforts to existing PPS systems are also under way. We are also working to implement demonstrations that align hospital and physician incentives, including all-inclusive payments for hospital and physician services for specific inpatient episodes of care. In addition, we are working to implement numerous payment and service delivery demonstrations mandated by the Medicare Modernization Act.

Direct and Indirect Effects of the Changes in Home Health Policy and an Analysis of the Skill Mix of Medicare Home Health Services Before and After the Balanced Budget Act of 1997

Project No: HCFA-00-0108
Project Officer: Ann Meadow
Period: March, 2000 to December, 2003
Funding: $24,298
Principal Investigator: Nelda McCall
Award: Simplified Acquisition
Awardee: Laguna Research Associates
455 Market Street, Suite 1190
San Francisco, CA 94105

Description: This project provides partial support for a project primarily funded by the Robert Wood Johnson Foundation (RWJ). As part of this larger project, CMS supplies needed data and receives the results of a special study. The RWJ project examines three areas where impacts of the Balanced Budget Act of 1997 (BBA) might fall: the Medicare beneficiary, home health care agencies, and the overall medical and long-term care system. The special study for CMS looks at beneficiary access, as measured by patterns of Medicare home health use before and soon after the implementation of the BBA. The focus is on assessing whether changes occurred in the skill mix of types of visits received by home health users. The analysis also seeks information on possible differential effects for different categories of home health users and in different geographic areas.

Status: This project has been completed. A partial list of reports and publications follows:

- N. McCall et al., "Medicare Home Health Before and After the BBA," *Health Affairs* (May/June 2001): 189–198.
- H. Komisar, "Rolling Back Medicare Home Health," *Health Care Financing Review* (Winter 2002): 33–56.
- N. McCall et al., "Constraining Medicare Home Health Reimbursement: What Are the Outcomes?" *Health Care Financing Review* (Winter 2002): 57–76.
- N. McCall et al., "Utilization of Home Health Services Before and After the Balanced Budget Act of 1997: What Were the Initial Effects?" *Health Services Research* (February 2003): 85–106.
- N. McCall et al., "Decreased Home Health Use: Does It Decrease Satisfaction?" *Medical Care Research and Review* (forthcoming).
- N. McCall et al., "Reforming Medicare Payment: Early Effects of the 1997 Balanced Budget Act on Postacute Care," *MilbankQuarterly* 81, no. 2 (2003): 277–303.
- V. Cheh and W. Black, "Striking a Balance in Home Health Payment Reforms," Mathematica Policy Research, Inc. (June 2003).
- C. Murtaugh et al., "Trends in Medicare Home Health Care Use: 1997–2001," *Health Affairs* 22, no. 5 (Sept./Oct. 2003): 146-156.
- S. Rogers and H. Komisar, "Effects of the Balanced Budget Act on Medicare Home Health Agencies, Services and Clients: Findings from Interviews with Home Care Associations and Agencies" Final Report to the Robert Wood Johnson Foundation and the Centers for Medicare & Medicaid Services. Institute for Health Care Research and Policy, Georgetown University. Washington, DC, June 2002. ■

Studies in Home Health Case Mix

Project No: 500-00-0032/03
Project Officer: Ann Meadow
Period: September, 2001 to December, 2005
Funding: $739,713
Principal Investigator: Marian Wrobel, Ph.D.
Award: Task Order
Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138

Description: The main purpose of this project is to further develop the case mix model used for the home health prospective payment system (PPS) implemented in October 2000 and to explore new approaches to case mix adjuster development. Some of the results may have near- or medium-term application to CMS rulemaking for Medicare home health payment because they are essentially extensions of the current model. Other results are not necessarily extensions of the current model and therefore might find application in the long-term future. Additional tasks in this project involve maintenance of the home health PPS grouper and other types of technical assistance. All work will be conducted using existing administrative databases.

Status: Analyses have been conducted on a 20-percent sample of claims from the first six quarters of PPS, sometimes making use of simulated episodes from earlier periods for comparison. Analyses have been directed at such issues as performance of the existing adjuster for long-stay patients, feasibility of an adjuster for supplies costs, prediction of therapy costs and other approaches addressing the therapy visit threshold, performance of additional diagnosis groups, miscellaneous refinements of existing diagnosis groups, and time trends in Outcome and Assessment Information Set item coding. Further work will include retesting interim results on more recent data. ■

Medicare Post-Acute Care: Evaluation of BBA Payment Policies and Related Changes

Project No: 500-96-0006/04
Project Officer: Philip Cotterill
Period: September, 2000 to September, 2004
Funding: $636,557
Principal Investigator: Brian Burwell
Award: Task Order
Awardee: Medstat Group (DC)
600 Maryland Avenue, SW,
Suite 550
Washington, DC 20024-2512

Description: The purpose of this project is to study the impact of BBA and other policy changes on Medicare utilization and delivery patterns of post-acute care. Post-acute care is generally defined to include the Medicare covered services provided by skilled nursing facilities (SNFs), home health agencies, rehabilitation hospitals and distinct part units, long-term care hospitals, and outpatient rehabilitation providers. The changes in post-acute care payment policy enacted in the late 1990s (mostly in the 1997 Balanced Budget Act (BBA) with some subsequent modifications) were made one-by-one to most types of post-acute care. However, a beneficiary's post-acute care needs can often be met in alternative provider settings. Therefore, policy changes for one post-acute care modality may have ramifications for other post-acute and acute care services. Understanding the interrelationships among post-acute care delivery systems is critical to the development of policies that encourage appropriate and cost-effective use of the entire range of care settings. The results of this work may be useful in refining policies for individual types of post-acute care, as well as in developing a more coordinated approach across all settings. This initial project will compare changes between the pre-BBA period of the 1990s and the post-BBA year, 1999. The study will include a variety of beneficiary, provider, and market area analyses. Since the impacts of policy changes not yet implemented will continue to be of interest for many years, the analyses developed under this contract are expected to use and refine methods that can be applied in future evaluation research.

Status: A final report containing descriptive and multivariate analyses of post-acute episodes of care during the period 1996–2002 is expected by September 2004. ■

Assessment, Refinement, and Analysis of the Existing Prospective Payment System for Skilled Nursing Facilities

Project No: 500-00-0025/02
Project Officer: Jeanette Kranacs
Period: July, 2001 to July, 2005
Funding: $6,383,566
Principal Investigator: Korbin Liu
Award: Task Order
Awardee: Urban Institute
2100 M Street, NW
Washington, DC 20037

Description: This project supports CMS in (1) the assessment of the feasibility of refining the current Medicare payment system for skilled nursing facilities, and if feasible, produce analyses that support these refinements, and (2) our exploration of different systems for categorizing patients and their resource allocation. It will analyze data and prepare a report containing recommendations for possible revisions to the classification of patients in a manner that accounts for the relative resource use of different patient types.

Status: Phase I focused on the design and creation of a database. Phase II analyses support annual refinements to the payment system and analysis, testing, simulations, and making recommendations regarding potential options for modifying, restructuring, or reconfiguring the existing patient classification and payment system for skilled nursing facilities. ■

Evaluation of Issues Related to Prospective Payment System under Consolidated Bidding for Skilled Nursing Facilities and Home Health Agencies

Project No: 500-96-0026/14
Project Officer: Cindy Murphy
Period: August, 1999 to June, 2003
Funding: $938,370
Principal Investigators: Sam McNeill, George Kowalczyk, and Frank Spruill
Award: Task Order
Awardee: Jing Xing Technologies
1312 Vincent Place
P.O. Box 6655
McLean, VA 22106-6655

Description: This project provides analytical support for CMS on operating issues (claims processing, medical review (MR), and data processing) for providers and contractors (intermediaries, carriers, and durable medical equipment regional carriers) related to implementation of the skilled nursing facility (SNF) Part A prospective payment system, consolidated billing under Parts A and B, and implementation of the new SNF Part B fee schedule. Operating issues include.

- Intermediary medical review processes
- Avoiding duplicate payments
- Implementing the SNF Part B fee schedule
- Editing criteria and processing rules for SNF claims
- Training materials
- Consolidating billing for home health issues

Status: A report submitted with recommendations is available. The remaining activities include:

- Complete development of automation for fiscal intermediary MR
- Complete development of enhanced coverage edits for FY 2001 resource utilization groups
- Complete development of specifications for focused MR for FY 2001 resource utilization groups
- Complete development of query file for SNFs to ascertain Part A and Part B
- Status of specific CMS Common Procedure Coding System codes
- Complete development of paid claims data analysis related to potential duplicate payment of SNF claims
- Miscellaneous other data analysis reports. ■

Mercy Medical Skilled Nursing Home Payment Demonstration

Project No: 95-W-00083/04
Project Officer: J. Donald Sherwood
Period: January, 2002 to December, 2004
Funding: $0
Principal Investigator: Kathryn Parks
Award: Waiver-Only Project
Awardee: Mercy Medical
101 Villa Drive
P.O. Box 1090
Daphne, AL 36526-1090

Description: This pilot study is viewed as a period of evaluation for the purpose of working toward crafting an alternative approach to financing post-acute care that features greater integration of services and episodic payment. During the demonstration period, Mercy Medical is being paid according to the payment methodology that was used during the 2-year period authorized by the Balanced Budget Refinement Act of 1999 (BBRA), i.e., a per diem payment based on historical cost.

Status: Mercy Medical is developing a proposal for a 5-year demonstration to test an alternative approach to financing post-acute care that features increased integration of services and a bundled payment for select diagnoses. The post-acute services include inpatient rehabilitation hospital, SNF, and home health. For qualifying Medicare patients in the diagnostic categories of cerebrovascular accident (CVA)/stroke, cardiopulmonary, and orthopedic, Mercy Medical would be paid a single bundled payment for a defined 100-day episode of care. For Medicare patients not in the select diagnosis groups, Mercy Medical will continue to receive the inpatient rehab prospective payment system (PPS), home health agency PPS, and the waivered SNF payment as defined in BBRA. ■

Design, Development, Implementation, Monitoring, and Refinement of a Prospective Payment System for Inpatient Rehabilitation

Project No: 500-95-0056/08
Project Officer: Jeanette Kranacs
Period: July, 1999 to September, 2004
Funding: $5,908,651
Principal Investigators: Grace Carter and Melinda Beeuwkes Buntin
Award: Task Order
Awardee: RAND Corporation
1700 Main Street
P.O. Box 2138
Santa Monica, CA 90407-2138

Description: The purpose of this project is to support the design, development, implementation, monitoring, and refinement of a case-based prospective payment system (PPS) for rehabilitation facilities providing services to Medicare beneficiaries. Phase I of this project has been completed. This research has supported the development of a PPS for inpatient rehabilitation. This included the assessment and development of a classification system based upon both UDSmr and MEDIRISK data and focused on the Medicare population. The project will assess the feasibility of including or considering additional MDS PAC variables and assess the potential impact of the FIM-FRG classification system and subsequent payment system.

Phase II of this contract will be creating a national database merging the Inpatient Rehabilitation Facility Patient Assessment Instrument with CMS administrative data to analyze the case mix groups and the facility adjustments for refinements to the payment systems, as well as analysis of special cases, i.e., day and cost outliers, short stays, deaths, transfers, and interrupted stays. Phase II will advise and assist CMS in developing a monitoring system to assess the impact of the inpatient PPS and analyze the results of the staff time measurement study to assess compression. Additional tasks that will be addressed in the second phase of this contract include the impact of specific departments within the facilities or exempt units, assessing the impact of technological innovations on functional groups of the payment system, analysis of the activities of daily living (ADLs) to predict disability status and payment, and continued analysis of the impact of motor and cognitive variables on predicting disability status and payment. This phase will continue to analyze the impact of impairment groups, with and without comorbidities, and analyze the impact of comorbidities and their relationship to RICs and complexities.

Status: A work plan and interim report on "Inpatient Rehabilitation Facility Prospective Payment System" for Phase I is available. Additional reports and the work plan for Phase II are also available. ■

Psychiatric Inpatient Routine Cost Analysis

Project No: 500-95-0058/13
Project Officer: Frederick Thomas
Period: September, 2000 to December, 2004
Funding: $2,432,014
Principal Investigator: Jerry Cromwell
Award: Task Order
Awardee: Research Triangle Institute
411 Waverley Oaks Road, Suite 330
Waltham, MA 02452-8414

Description: The Balanced Budget Refinement Act of 1999 (BBRA) (1999) requires the Secretary to report on a per diem-based PPS with an adequate patient classification system for psychiatric hospitals and distinct part units by October 1, 2001. Previous research on inpatient psychiatric cost variation focused on explaining per-case cost differences, primarily using diagnosis-related groups (DRGs). However, little, if any, research has been done on psychiatric per diem cost variation. Three inpatient cost components are recorded in the Medicare cost report: ancillary, overhead, and general routine care (adults and pediatrics). The largest of these components, general routine care, represents about two-thirds of the total cost of delivering inpatient services in exempted psychiatric facilities. Unfortunately the cost report does not detail the services that are provided in this cost category. In order to understand the dynamics of psychiatric per diem cost variation, and in particular, the variation in per diem routine costs, basic data collection and analytical work will be conducted under this project. In order to understand the dynamics of psychiatric per diem cost variation, and in particular, the variation in per diem routine costs, basic data collection and analytical work will be conducted under this project. These data will be used to construct a typology of routine inpatient

psychiatric services. The variations in these services will then be analyzed at the patient level to answer the following questions:

- Do routine services vary across facility types?
- Do routine services differ between homogeneous patient categories holding facility groups constant?
- How do different staffing models influence routine cost variation?
- How do patient types influence resource usage?
- How does resource intensity vary within a patient stay?
- What patient level factors affect resource usage?

Facility and patient level data will be gathered at over 40 sites by the end of the contract period. Data are collected for a 1-week period during each of 3 shifts (24/7).

Status: The final project report is being reviewed. ■

Practice Expense Methodology

Project No: 500-95-0059/06
Project Officer: Ken Marsalek
Period: May, 1999 to May, 2004
Funding: $655,710
Principal Investigator: Allen Dobson
Award: Task Order
Awardee: Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church,VA 22042

Description: This project provided technical assistance to evaluate various aspects of the practice expense methodology for the Medicare Physician Fee Schedule. Until January 1992, Medicare paid for physicians' services based on a reasonable charge system. This system led to payment variations among types of services, physician specialties, and geographic areas. In 1989 Congress established a fee schedule for the payment of physicians' services. Under the formula set forth in the law, the payment amount for each service is the product of three factors:

1. A nationally uniform relative value
2. A geographic adjustment factor for each physician fee schedule area
3. A nationally uniform conversion factor that converts the relative value units (RVUs) into payment amounts for services

The RVUs for each service reflect the resources involved in furnishing the three components of a physician's service:

1. Physician work (i.e., a physician's own time and effort)
2. Practice expenses net of malpractice expenses
3. Malpractice insurance expenses

The original practice expense RVUs were derived from 1991 historical allowed charges. A common criticism was that for many items these RVUs were not resource-based because they were not directly based on the physicians' resource inputs. CMS was required to implement a system of resource-based practice expense relative value units (PERVUs) for all physicians' services by 1998. The Balanced Budget Act of 1997 (BBA) made a number of changes to the system for determining PERVUs, including delay of initial implementation until 1999 and provision for a 4-year transition. To obtain practice expense data at the procedure code level, CMS convened Clinical Practice Expert Panels (CPEPs). The CPEPs provided the direct inputs of physician services, i.e., the amount of clinical and administrative staff time associated with a specific procedure and medical equipment and medical supplies associated with a specific procedure. In June 1997, we published a proposed rule for implementing resource-based practice expense payments. The methodology incorporated elements of the CPEP process to develop the direct expense portion of the PERVU. The indirect expense portion of the PERVU was based on an allocation formula. In addition to delaying the implementation of resource-based practice expense payments until January 1, 1999, the BBA phased in the new payments over a 4-year transition period. In developing new practice expense RVUs, we were required to:

- Utilize, to the maximum extent practicable, generally accepted cost accounting principles that recognize all staff, equipment, supplies, and expenses, not just those that can be linked to specific procedures
- Use actual data on equipment utilization and other key assumptions
- Consult with organizations representing physicians regarding methodology and data to be used
- Develop a refinement process to be used during each of the 4 years of the transition period

In June 1998, we proposed a methodology for computing resource-based practice expense RVUs that uses the two significant sources of actual practice expense data we have available: CPEP data and the American Medical Association's (AMA) Socioeconomic Monitoring System (SMS) data. This methodology is based on an assumption that current aggregate specialty practice costs are a reasonable way to establish initial estimates of the relative resource costs of physicians' services across specialties. It then allocates these aggregate specialty practice costs to specific procedures and,

thus, can be seen as a "top-down" approach. We used actual practice expense data by specialty to create six cost pools: administrative labor, clinical labor, medical supplies, medical equipment, office supplies, and all other expenses. There were three steps in the creation of the cost pools:

1. We used the AMA's SMS survey of actual cost data to determine practice expenses per hour by cost category.
2. We determined the total number of physician hours, by specialty, spent treating Medicare patients.
3. We then calculated the practice expense pools by specialty and by cost category by multiplying the practice expenses per hour for each category by the total physician hours.

For each specialty, we separated the six practice expense pools into two groups and used a different allocation basis for each group. For group one, which includes clinical labor, medical supplies, and medical equipment, we used the CPEP data as the allocation basis. The CPEP data for clinical labor, medical supplies, and medical equipment were used to allocate the clinical labor, medical supplies, and medical equipment cost pools, respectively. For group two, which includes administrative labor, office expenses, and all other expenses, a combination of the group one cost allocations and the physician fee schedule work RVUs were used to allocate the cost pools. For procedures performed by more than one specialty, the final procedure code allocation was a weighted average of allocations for the specialties that perform the procedure, with the weights being the frequency with which each specialty performs the procedure on Medicare patients. The BBA also requires the Secretary to develop a refinement process to be used during each of the 4 years of the period. In the 1998 notice, we finalized the proposed methodology but stated that the PERVUs would be interim throughout the transition period. Additionally, we envisioned a two-part refinement process.

Status: The project staff were concerned with the data involved in the project. They met with CMS and the AMA to discuss our future use of the AMA's existing SMS survey and to discuss the design and structure of its new practice-level survey. The AMA plans to conduct its survey of practices in alternating years with the SMS survey. The project staff completed an evaluation of the 1998 SMS questionnaire and an initial review of the methodology of the practice expense per hour values derived from the SMS data. They developed recommendations regarding the practice survey design and methodology and considered how the practice-level survey could be used and how the information could be cross-walked to the SMS survey. In addition, they met with medical specialty organizations to review and make recommendations on data that might be of use and to hear concerns about the AMA SMS survey.

- The AMA has proposed the establishment of an RVU Practice Expense Advisory Committee to review detailed, Current Procedural Terminology code level input data.
- CMS will request contractual support for assistance on methodology issues. This project provides that contractual support. ■

5 Year Review of Malpractice Relative Value Units

Project No: 500-00-0017/01
Project Officer: Rick Ensor
Period: September, 2003 to March, 2005
Funding: $269,111
Principal Investigator: Jim Moser
Award: Task Order
Awardee: BearingPoint
1676 International Drive
McLean, VA 22102-4828

Description: The purpose of this procurement is to update the MPRVUs associated with Part B Medicare Physician Fee Schedule services. MPRVUs are one component of a fee schedule payment that by law must be updated no less than every 5 years.

Over the past year there has been substantial media coverage associated with escalating malpractice premiums for physicians. Many physician specialties are experiencing inordinate increases as compared to other physician specialties. The development of revised MPRVUs will incorporate more current specialty specific malpractice premium data that will make the MPRVU component of the physician fee schedule payment amount for an individual service, a more accurate depiction of the resources cost associated with physicians purchasing malpractice insurance coverage.

The methodology that will be used to incorporate the malpractice premiums of the 20 largest Medicare specialties (as measured by total Medicare utilization provided by CMS) into the final MPRVUs will be identical to the methodology that was utilized by KPMG, under contract to CMS, in the October 2000 Technical Addendum to the 4/7/99 Report on Resource-Based Malpractice RVUs (Task Order 0038). CMS will provide this Technical Addendum to the winner of the contract.

Status: BearingPoint is currently working on various technical issues that will need to be addressed in order to complete this contract. BearingPoint has been on time with all deliverables and the contract is on schedule. ■

Environmental Scan for Selective Contracting Practices With Efficient (Qualified) Physicians and Physician Group Practices, Profiling Techniques, Incentive Payments, and Barriers to Selective Contracting

Project No: 500-00-0030/01
Project Officer: Benson Dutton
Period: September, 2001 to March, 2003
Funding: $303,803
Principal Investigator: Gregory Pope
Award: Task Order
Awardee: Research Triangle Institute
411 Waverley Oaks Road, Suite 330
Waltham, MA 02452-8414

Description: This project undertakes an environmental scan of physician service payers/employers to identify (1) recent fee-for-service payer and managed care plan selective contracting arrangements with efficient/high-quality physicians and physician-group practices; (2) best practice profiling methodology/criteria used in selective contracting including financial profiling; (3) barriers to selective contracting such as "any-willing-provider" or "freedom-of-choice" laws; and (4) bonus arrangements being paid to high-quality physicians. Descriptive and qualitative analyses based on this environmental scan should lead to a recommendation of best practice profiling criteria that identify efficient and qualified physicians and group practices. Quantitative analyses estimate current Medicare (Part B) physician expenditures and simulate possible program savings (losses) from alternative selective contracting policies based on best industry practice found in the environmental scan. The use of physician profiling (quality and economic) by payers and employers in evaluating physicians for the purposes of staff appointment, reappointment, and/or selective contracting has been suggested as an accepted industry practice that would modernize Medicare payment practices. In addition, the use of bonus payments to efficient and high-quality physicians to keep Medicare program costs down and quality of service up is cited as another industry practice appropriate for modernization of Medicare.

Status: The contractor completed Phase I of the project, and a final report was delivered December 31, 2003. ■

Implementation Support for the Medicare Participating Centers of Excellence Demonstration

Project No: 500-00-0037/02
Project Officer: Raymond Wedgeworth
Period: September, 2001 to March, 2005
Funding: $379,991
Principal Investigator: Kenneth Cahill
Award: Task Order
Awardee: BearingPoint
1676 International Drive
McLean, VA 22102-4828

Description: The purpose of this project is to assist CMS in the implementation of the Quality Partnerships Demonstration Project. Under this demonstration, CMS selects premier cardiovascular and orthopedic programs and gives a bundled Part A and Part B payment (global payment) for all inpatient facility and physician services related to specific diagnosis-related groups. Implementation support includes: (1) calculating the appropriate payment rates (both initial and annual updates); (2) developing the Office of Management and Budget waiver cost estimate; (3) educating demonstration sites regarding payment calculations; (4) planning and implementing a predemonstration implementation conference; and (5) providing general technical support to CMS in carrying out the demonstration.

Status: The project is under way. ■

Quality Monitoring for the Medicare Participating Centers of Excellence Demonstration

Project No: 500-00-0032/01
Project Officer: Jody Blatt
Period: September, 2001 to December, 2005
Funding: $735,160
Principal Investigator: Oren Grad
Award: Task Order
Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138

Description: The purpose of the quality monitoring project is to develop a quality monitoring process that meets the general goals of various global payment demonstrations, including the Medicare Partnerships for Quality Cardiovascular Services and Medicare Partnerships for Quality Total Joint Replacement Services (referred to as Quality Partnerships for short and formerly referred to as the Medicare Participating Centers of Excellence Demonstration) and, subsequently, to coordinate and implement that process. The process

incorporates the identification and technical definition of appropriate performance measures, collection of data in a centralized database, the development and distribution of reports to provide meaningful information back to demonstration participants and CMS, and coordination of the quality consortia meetings and conferences. The Quality Partnerships Demonstration involves bundled Part A and Part B payments to premier cardiovascular and orthopedic facilities for selected procedures. The selected cardiovascular and orthopedic procedures include coronary artery bypass surgery, cardiac valve procedures, angioplasty, and knee and hip replacements. We expect that the use of global payments will align the incentives for efficiency between the hospitals and the physicians, thereby enhancing not only the efficiency but the clinical quality of services. All of the selected demonstration sites are invited to participate in a specialty-specific quality consortia that develops quality criteria and quantitative measures for monitoring performance during the demonstration.

Status: Implementation activities for the Medicare Quality Partnerships Demonstration (originally referred to as the Medicare Participating Centers of Excellence Demonstration) were suspended in late 2002. No sites were operational as of that date. No further implementation activity on this demonstration is currently planned. However, the contract did complete the required literature reviews on the status of quality measures for cardiovascular surgery, total hip and knee replacements, and general inpatient services.

Further work under this contract will be used to support other global payment demonstration quality initiatives. ■

Evaluation of the New Jersey Hospital Association Demonstration of Performance Based Incentives: Part 2.

Project No: 500-00-0024/15
Project Officer: Benson Dutton
Period: September, 2003 to September, 2005
Funding: $148,349
Principal Investigator: Jerry Cromwell
Award: Task Order
Awardee: Research Triangle Institute (NC)
3040 Cornwallis Road
P.O. Box 12194
Research Triangle Park, NC
27709-2194

Description: The goal of the demonstration is to test the feasibility and cost-effectiveness of incentive payments to physicians for inpatient procedure episodes. The demonstration hospitals will be permitted to set savings goals and make incentive payments to physicians when the goals are achieved. The evaluation of the demonstration will assess the overall performance of these hospitals over the course of the demonstration period. The evaluation of the demonstration is intended to explore the overall potential of this alternative payment approach as a means to provide health care at reduced prices by providing the opportunity for a lower cost but more coordinated service delivery through more flexible use of resources and streamlining administrative procedures without compromising quality or sacrificing patient satisfaction. This demonstration and its evaluation should provide additional operational information about this payment method for both the public and private sector.

The demonstration has currently been extended to a second state, Virginia, where it will examine heart surgery under the rubric Virginia Cardiac Surgery Initiative. The evaluator will be the same as for the New Jersey demonstration. Proposed funding for the Virginia part of the evaluation is $313,675 for 2 years.

Status: The Centers for Medicare & Medicaid Services (CMS) has begun to implement the demonstration both in New Jersey and in Virginia. ■

Integrated Payment Option Support Contract

Project No: 500-00-0024/06
Project Officer: Raymond Wedgeworth
Period: September, 2002 to September, 2006
Funding: $496,279
Principal Investigator: Gregory Pope
Award: Task Order
Awardee: Research Triangle Institute (DC)
1615 M Street, NW, Suite 740
Washington, DC 20036-3209

Description: This demonstration utilizes the capabilities of integrated delivery systems by offering them a financial incentive to manage care and integrate services for beneficiaries across an entire defined episode of care. One example of an episode of care is inpatient treatment and post-acute care for stroke where the patient would benefit from improved coordination of the range of services required for this diagnosis. A single episode payment would cover Part A (all benefits available to the covered population) and Part B (physician and possibly other services covered under Part B). This demonstration will compare alternate methods for calculating payment

rates using different assumptions such as co-morbid conditions, stage of diagnosis, and mix of services.

Status: CMS plans to implement the Integrated Payment Option demonstration in January 2005. CMS will select premier integrated delivery systems and give a bundled Part A and Part B payment (global payment) for all inpatient facility, post-acute, and physician services related to three to five specific diagnosis-related groups. Six to eight sites will be selected. ■

Evaluation of Competitive Bidding Demonstration for DME and POS

Project No: 500-95-0061/03
Project Officer: Ann Meadow
Period: September, 1998 to June, 2004
Funding: $2,315,249
Principal Investigators: Thomas J. Hoerger, Ph.D. and Sarita Karon, Ph.D.
Award: Task Order
Awardee: University of Wisconsin – Madison
750 University Avenue
Madison, WI 53706

Description: In 1999 the agency mounted a demonstration to test the feasibility and effectiveness of establishing Medicare fees for durable medical equipment (DME) and prosthetics, prosthetic devices, orthotics, and supplies (POS) through a competitive bidding process. The fundamental objective of competitive bidding is to use marketplace competition to establish market-based prices and to select DME suppliers. The Balanced Budget Act of 1997 (BBA) authorized competitive bidding demonstrations for Part B services (except physician services), and the project was conducted under that authority. The initial site of the demonstration was Polk County, Florida. A second site, San Antonio, Texas, was added in 2000. Competitively bid product categories in Polk were oxygen supplies and equipment, hospital beds, enteral nutrition, surgical dressings, and urological supplies. Product categories in Texas were oxygen supplies and equipment, hospital beds, manual wheelchairs, nebulizer drugs, and noncustomized orthotics. Medicare contracts with winning suppliers in Polk County commenced in October 1999, and San Antonio contracts were scheduled to commence in February 2001.

Section 4319 of the BBA specifically mandated evaluation studies addressing competitive bidding impacts on expenditures, quality, access, and diversity of product selection. This task order studies these and other outcomes of the demonstration. The evaluation uses several types of research designs, such as multiple time series analysis and pre-test/post-test comparisons. The results of the evaluation will help the Agency decide how to conduct any future competitive bidding activities.

Status: The Second Annual Report to Congress was released in 2002. It provided the following interim findings: after the second round of bidding in Florida and the single round of bidding in San Antonio, the evaluation team estimated savings of approximately 20 percent in Medicare allowed charges for the goods and services involved. The before/after beneficiary survey in Polk County revealed little impact of the demonstration unfavorable for access or quality. For example, respondents rated their suppliers equally well at both time points. However, one survey indicator suggested there was a decline in the use of portable oxygen, which could have quality-of-life implications. It is not clear whether this was due to cost-saving behavior among the suppliers. Results from the second round of bidding in Polk County and information from suppliers there suggested that the market remained reasonably competitive.

In San Antonio, the bidding competition attracted 79 firms. Despite the larger scale of operations in San Antonio, public education, supplier preparation, and bid evaluation proceeded smoothly in most respects. Anecdotal information on access and quality impacts in San Antonio was partly mixed, with some problems in wheelchair services reported early in the operations.

The interim results suggested that Medicare's policy objectives in terms of savings, access, quality, competition, and administrative feasibility may be adequately served under competitive bidding. These tentative findings are supplemented with survey data from beneficiaries and suppliers, as well as detailed claims analyses, in the third and final Report to Congress, which is awaiting clearance and release. ■

Municipal Health Services Programs

This project supports the Municipal Health Services Program (MHSP), originally established through a collaborative effort of the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and CMS. CMS provides Medicare waivers to test the effects of increased utilization of municipal health centers by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented utilization from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care. Waivers and grants were awarded to Baltimore, Cincinnati, Milwaukee, and San Jose in June 1978.

Status: Congress has extended the demonstration several times. More recently, the Balanced Budget Act of 1997 extended the demonstration until December 31, 2000; the Balanced Budget Reconciliation Act of 1999 extended the demonstration until December 31, 2002; and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 extended it until December 2004. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 extended the demonstration until December 21, 2006. The demonstration does not accept new participants and is restricted to those who were in the program as of 1997. An earlier evaluation of the cost effectiveness of the demonstration indicated that a large proportion of the increase in program costs was caused by the rise in the utilization of high-cost ancillary services, e.g., prescription drugs, dental care, and vision care. These were not offset by decreases in emergency and hospital usage. ■

Municipal Health Services Programs: Baltimore

Project No: 95-P-51000/03
Project Officer: Ronald Deacon
Period: June, 1978 to December, 2006
Funding: $0
Principal Investigator: Sherry Adeyemi
Award: Service Agreement
Awardee: City of Baltimore
111 North Calvert Street
Baltimore, MD 21020

Municipal Health Services Program: Cincinnati

Project No: 95-P-51000/05a
Project Officer: Ronald Deacon
Period: June, 1978 to December, 2006
Funding: $0
Principal Investigator: Daryl Cammerer
Award: Service Agreement
Awardee: City of Cincinnati
3101 Burnet Avenue
Cincinnati, OH 45229

Municipal Health Services Program: Milwaukee

Project No: 95-P-51000/05
Project Officer: Ronald Deacon
Period: June, 1978 to December, 2006
Funding: $0
Principal Investigator: Samuel Akpan
Award: Service Agreement
Awardee: City of Milwaukee
841 North Broadway
Milwaukee, WI 53202

Municipal Health Services Program: San Jose

Project No: 95-P-51000/09
Project Officer: Ronald Deacon
Period: June, 1978 to December, 2004
Funding: $0
Principal Investigator: Laura Talavera
Award: Service Agreement
Awardee: City of San Jose
151 West Mission Street
San Jose, CA 95110

NEW YORK GRADUATE MEDICAL EDUCATION (GME) DEMONSTRATIONS

This is a participant in a major demonstration that provided incentives for New York State teaching hospitals to reduce their graduate medical residencies by 20 to 25 percent over a 5-year period. Medicare's annual GME spending reached $7 billion, of which nearly 20 percent was for New York teaching hospitals. The project was expected to reduce the number of residents and thus reduce the costs of the program. Concerns were that such a reduction would impact access and service delivery as well as having economic and workforce effects.

New York Graduate Medical Education (GME) Demonstration: North Central Bronx Hospital Joint Project

Project No: 95-W-00030/02
Project Officer: Sid Mazumdar
Period: February, 1997 to June, 2003
Funding: $0
Principal Investigator:
Award: Waiver-Only Project
Awardee: North Central Bronx Hospital
1400 Pelham South
Suite 159 Jacobi
Bronx, NY 10461

Status: North Central Bronx Hospital has remained in the demonstration for the duration of the period of performance. ■

New York Graduate Medical Education (GME) Demonstration: Lincoln Medical and Mental Health Center

Project No: 95-W-00033/02
Project Officer: Sid Mazumdar
Period: February, 1997 to June, 2003
Funding: $0
Principal Investigator:
Award: Waiver-Only Project
Awardee: Lincoln Medical and Mental Health Center
234 East 149th Street
Bronx, NY 10451

Status: Lincoln Medical and Mental Health Center has remained in the demonstration for the duration of the period of performance. ■

New York Graduate Medical Education (GME) Demonstration: Metropolitan Hospital Center

Project No: 95-W-00036/02
Project Officer: Sid Mazumdar
Period: February, 1997 to June, 2003
Funding: $0
Principal Investigator:
Award: Waiver-Only Project
Awardee: Metropolitan Hospital Center
1901 First Street
New York City, NY 10029

Status: Metropolitan Hospital Center has remained in the demonstration for the duration of the period of performance. ■

New York Graduate Medical Education (GME) Demonstration: Brooklyn Hospital Center

Project No: 95-W-00042/02
Project Officer: Sid Mazumdar
Period: February, 1997 to June, 2003
Funding: $0
Principal Investigator:
Award: Waiver-Only Project
Awardee: Brooklyn Hospital Center
270 Flatbush Avenue Extension
Brooklyn, NY 11201

Status: The consortium members are Bellevue Hospital Center, Brooklyn Hospital Center, Hospital for Joint Diseases, Lenox Hill Hospital, New York University Downtown Hospital, and New York University Medical Center. The consortium has remained in the demonstration for the duration of the period of performance. ■

New York Graduate Medical Education Demonstration (GME): Interfaith Medical Center

Project No: 95-W-00035/02
Project Officer: Sid Mazumdar
Period: February, 1997 to June, 2003
Funding: $0
Principal Investigator:
Award: Waiver-Only Project
Awardee: Interfaith Medical Center
1545 Atlantic Avenue
Brooklyn, NY 11213

Status: Interfaith Medical Center has remained in the demonstration for the duration of the period of performance. ■

New York Graduate Medical Education Demonstration: Harlem Hospital Center

Project No: 95-W-00029/02
Project Officer: Sid Mazumdar
Period: February, 1997 to June, 2003
Funding: $0
Principal Investigator:
Award: Waiver-Only Project
Awardee: Harlem Hospital Center
506 Lenox Avenue
New York, NY 10037-1802

Status: Harlem Hospital Center remains in the demonstration ■

New York Graduate Medical Education Demonstration: Mount Sinai Consortium

Project No: 95-W-00038/02
Project Officer: Sid Mazumdar
Period: February, 1997 to June, 2003
Funding: $0
Principal Investigator:
Award: Waiver-Only Project
Awardee: Brooklyn Hospital Center
207 Flatbush Avenue Extension
Brooklyn, NY 11201

Status: The Consortium members are Cabrini Medical Center, Elmhurst Hospital Center, Mount Sinai Medical Center, and Queens Hospital Center. The consortium has remained in the demonstration for the duration of the period of performance. ■

Evaluation of the New York Medicare Graduate Medical Education Payment Demonstration and Related Provisions

Project No: 500-95-0058/10
Project Officer: William Buczko
Period: September, 1999 to September, 2004
Funding: $1,692,751
Principal Investigator: Jerry Cromwell
Award: Task Order
Awardee: Research Triangle Institute
411 Waverly Oaks Road, Suite 330
Waltham, MA 02452-8414

Description: This is a coordinated evaluation of a major demonstration that provided incentives for New York State teaching hospitals to reduce their residencies by 20 to 25 percent over a 5-year period and several provisions of the Balanced Budget Act of 1997 (BBA), which were also aimed at reducing Medicare graduate medical education (GME) spending. Medicare annual GME spending reached $7 billion, of which nearly 20 percent was for New York teaching hospitals. The evaluation assesses the impacts of residency reduction on access and service delivery as well as effects on hospital fiscal status and physician workforce size and composition.

Status: "Recommended Design and Strategy for NY GME Demonstration and National BBA GME Provisions" is available from the National Technical Information Service, accession number PB99-175063. There are a series of reports available, including a summary report on the New York GME demonstration during the period from July 1, 1997, through December 31, 2003. ■

Rationalize Graduate Medical Education Funding

Project No: 18-C-91117/08
Project Officer: Sid Mazumdar
Period: February, 2000 to June, 2007
Funding: $839,875
Principal Investigator: Gar Elison
Award: Cooperative Ageement
Awardee: Medical Education Council
288 North 1460 West
P.O. Box 144101
Salt Lake City, UT 84114-4101

Description: Since 1997, CMS has been working with the State of Utah on a project that will pay Medicare direct and indirect graduate medical education funds ordinarily received by the State's hospitals to the State of Utah Medical Education Council. GME funds will be distributed to training sites and programs according to the Council's research on workforce needs.

Status: The Utah Medical Education Council is currently participating in the demonstration with CMS. ■